

Follow wife

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

	Print Name: Courter Bank		Date of I	Rennest:	5-24-	25.	
	ID# <u>20892/</u> Dat		1:		tion: 4		
	Nature of problem or request: L. Was				042 4/48	705. Ar. J	
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	Refer to: MD/PA Mental Health Den			nt Re	turn to Cli	nic PRN	4
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	Was MD/PA on call n	otified:	Yes () Yes ()	No () No ()			
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	WHITE: INMATES MEDICAL FILE			",	7. (
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•	POLSE 47 B/P 10 / 0 0	RECHECK IF SYSTOLIC / <100> 50
NATURE OF INJURY OR ILLNESS	ADDAGGOUGH	
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5-" I haven't had a bound		
movement in (2) days. It's		
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Causing a lot of gas & make		
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1 /1 · · · · · · · · · · · · · · · · · ·		TIME BY
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Requests Something for gas + bounds.		
Joseph Jo		
		
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DIAGNOSIS		
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INSTRUCTIONS TO PATIENT) 1 Dat 9/90	
· ·	400 A-1-20	
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05/19/05 130 PM DOC 1	TAMPIN THOSE	GE ⊒ POOR
NURSE'S SIGNATURE DATE PRESIDENT SEGNATURE	□ □ □ FAIR	CRITICAL
	S CONSULTATION	
Dustin 400 05/19/00 001	JINO	
INMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB	R/S FAC.
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ADMISSION DATE ADMISSION DATE	21NOYE	SICK CALL DEMERGENCY DOUTPATIENT
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independently. Color appropriate for		
A. a Hearting in mount	1 9119 111	RIGHT OR LEFT
P-ECG dole-normal		
ACB to review.	ORDERS / MEDICATIONS / IV FLUIDS	S TIME BY
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Turks '/" tabs NOW.		
DIAGNOSIS		
INSTRUCTIONS TO PATIENT		
DISCHARGE DATE TIME RELEASE / TRANSFERRED	TO ADOC COMPI	FION ON DISCHARGE
4/24/05 AM PM	AMBULANCE SATIS	SFACTORY DOOR CRITICAL
3. Shust X1, ON 4/24/5 11. They	DATE CONSU	LTATION
INMATE NAME (LAST, FIRST, MIDDLE)	DOC# [OOB R/S FAC.
1 Boud Courtney	2080	BNI Elniore



4 / 80 / 65 110 (AM) SIR PDL SIG	APEE OUTPATIENT	
ALLERGIES WX	CONDITION ON ADMISSION GOOD □ FAIR □ POOR □ SHOCK □ HEMORRHAGE □ COMP	Α
VITAL SIGNS: TEMP ORAL RECTAL RESP.	PULSE B/P () () RECHECK IF SYSTOLIC /	
NATURE OF INJURY OR HELNESS	ABRASION /// CONTUSION # BURN XX FRACTURE Z LACERATION / XX SUTUR	 RES
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	2 Mutation	\dashv
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INSTRUCTIONS TO PATIENT (A) Sections	E if whaten borred	_
DISCHARGE DATE TIME RELEASE / TRANSFERRED		\dashv
NURSE'S SIGNATURE DATE PHYSICIAN'S SIGNATURE	AMBU'LENCE SATISFACTORY POOR CRITICAL PATE CONSULTATION	_
INMATE NAME HAST, FIRST, MIDDLE)	DOC# DOB B/S FAC	
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ADMISSTION DATE TIME ORIG	SINATING FACILITY	SHU			101/ 04/1	
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ALLERGIES NKI		CONDITION (ON ADMISSION □ FAIR □ POOF	R □ SHOCH	HEMORR	RHAGE COMA
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S. 2 fell aff the Ruel (JEur	ABRASION ///	CONTUSION # B	URN XX FF		ACERATION / SUTURES
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	Village of the	Shots	Molny 4/13/R	COC	mg TIC	X Toloy
04 /18/05 AM PM	TRANSFERRED T	AMBU'LE	DATE CONSL	TION ON DIS SFACTORY ULTATION	□ POOR □ CRITIC	;AL
Bodd. Commen		21/20	ļ,	OOB	A/n	ITMOREO





PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Courtney 13042 Date of Request: 3-28-05	
ID # 20891 Date of Birth: Location: $CZ-95$	
Nature of problem or request: I can Still have back problem and I got	
To get my buell brace and Profile I (1):11 like to be seen	
by the doctor,	
Cory Ma	
Signature Signature	
DO NOT WRITE BELOW THIS LINE	
Date: 03/29/05	
Time: AM PM RECEIVED Date: 3/28/05 Time: 94 5	
Receiving Nurse Intials	
(S)ubjective: My hack is herting since 2003. I can have	ily
$C \wedge T$	
(O)bjective (V/S): \underline{T} : $\underline{Y'}$, \underline{I} : \underline{P} : \underline{US} R: \underline{L} BP: \underline{UZ} WT: \underline{I}	69
o radiating Bain described to hack	ai
The strong of the things les & numberer to (Hely tremety	
(A)ssessment: lower extremeties, (O)bjective (V/S): T: 97.7 P: (9 R: 20 BP: 12 WT: / Pain to spine + 1 hack Pulse strong, long to feet good, fairful stimuli ptimate notate (A)ssessment: lower extremeties,	¥J
alteration in Comput	
(P)lan: /tep to review	
Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN	
Check One: POLITINE (1) FAMERORNOUS	
Check One: ROUTINE (V) EMERGENCY () If Emergency was PHS supervisor notified: Yes () No () Was MD/PA on call notified: Yes () No ()	
- Daustin Ip	
SIGNATURE AND TITLE	
WHITE: INMATES MEDICAL FILE	



ADMISSTION DATE ORIGINATING FACILIT	Y Comore	
ADMISSTION DATE 03 / 03/05 937 A AM OSIR OPDL OESC	CAPEE DEP	☐ SICK CALL ☐ EMERGENCY ELECTRATIENT
ALLERGIES NICH	CONDITION ON ADMISSION 124GOOD FAIR POOR S	HOCK HEMORRHAGE COMA
VITAL SIGNS: TEMP 97. 6 ORAL RESP. 18	79	
NATURE OF INJURY OR ILLNESS	PULSE B/P	RECHECK IF SYSTOLIC / <100> 50
5-1 & 1400 Comi do to	ABRASION /// CONTUSION # BURN xx	EBACTURE Z LACERATION/
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PHYSICAL EXAMINATION O-Amturbated, slowly into Ex but 5 diff, ato 23. Skin W/D to the touch, respective et pullabored, Bending limited, Go pain & spasms noted, pulsed to		RIGHT OR LEFT
Extremities strong, painful stimula	ORDERS / MEDICATIONS / IV FLUIDS	TIME BY
noted,	P-1) Hap to never	ω
	1 1 1	bending x 2 day
A- Alteration in Comfort Prody Chard DIAGNOSIS 02 Sat 9878 INSTRUCTIONS TO PATIENT		
DISCHARGE DATE 03/03/05 PM AM AM AM AM AM AM AM AM AM	TO GOOC CONDITION OF SATISFACTO FAIR DATE CONSULTATION 33/3/5	ORY ☐ POOR ☐ CRITICAL
INMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB	R/S FAC.
Boyd Courtness.	2089>1	Bu Flmin





PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Couriney Boyd Date of Request: 2-21-05	
ID # 208921 Date of Birth: Location: C-2-95	-
Nature of problem or request: I kny e B need to get by back bruce.	_
The last one I had use took by office, because my prayle	-
ever so no more good. My eyes hust also I want	-
to see the doctor,	_
College full	-
Signature	
DO NOT WRITE BELOW THIS LINE	
Date: 0-21 221 00 Time: 7774 AM PM Allergies: NUA RECEIVED Date: Time: Receiving Nurse Intials	
Profile experied. I keed something for my eye	wsn
(O)bjective (V/S): T: 97.9 P: 60 R. 20 RP. M/T	. /ŠŠ
(O)bjective (V/S): T: 97.9 P: 60 R: 20 BP: WT Noted raised arew to b) top eyelid, small amount of is noted. Reguests new hair brake & Something for lye.	yecti
(A)ssessment: Altu ation in Comfait	
(P)lan: Hep & review -	
Seen 2/2/25.	-
Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic REN	9/
Check One: ROUTINE (4) EMERGENCY ()	
If Emergency was PHS supervisor notified: Yes () No ()	
Was MD/PA on call notified: Yes () No ()	
Daylund	
SIGNATURE AND TITLE	

WHITE: INMATES MEDICAL FILE



8/17 A Chat Manned I was also I I all all	Date/Time	Inmate's Name: Bould	Courtney	D.O.B.:	
	8/17/05	Chart scroened	by Mental	l Health	RHowers
				· · · · · · · · · · · · · · · · · · ·	



Follow Up

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

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Yes () No ()	If Emergency was PHS superv
Yes () No ()	Was MD/PA on
VATU	



Nursing Evaluation Tool:

Back Pain

Facility: Alabama Department of Correc	tions:			Į.
Patient Name: Boyd Court	ney			
Inmate Number: 20892 (·	First Date of Birth:		
Date of Report: U 125 1 UL	7	Time Seen: 220		e One
Subjective: Chief Complaint(s): In P. Onset: Churn (, both) New onset — Chronic of Pain Scale: (1-10) le possently Typ Location of Pain: V bask Next/mid-back/low back History: Immis Statks "It's hard (Confinue on back if necessary) LAC Statks "Sometimes I of the Statks "It's hard and may arms as number Associated symptoms: Pain on urination? Objective: Vital Signs: (If Indicated) T:	enny Me a condition exacerbation te: Sharp Dull Radiation of p d for me to go numb fro I grap a hold of No 19es PNO 19es 988 P: 7	Intermittent Constant	nt Numbress: I nout my hack sun and my the Cold Protection es Vomiting Inlo ing? Inlo I Yes B/P: 120	GOOUT. 1 No EYes brace 4 legs feel e i additional notes on back of Yes (x
Back Exam: Prender to touch Contus	ion Muscle spasms	☐ Impaired range of mo	tion	_'
Additional Findings: Numbness Tingling Elaborate positive findings: Denics r			☐ Foot drop ☐ Other:_	
Elaborate positive findings:	MIDITES CO	presern		······································
			☐ Check Here if additional	notes on back
_	Abnormal (Describe): Absent			
Landitional Examination: Denythemocontinue on back it necessary Inmak is able to twist necessary Scio pain facial grima Assessment: (Referral Status) Referral NOT Required	Hate to sign	copy and sh	Histandus fr	Dimpaired Dim Chair e if continued on back AND noted
	Presence of RBCs from Presence of WBCs from	dipstick - Recurrent C	Complaint (More than 2 visits	for the same complaint)
Plan: Check All That Apply: □ Work and recreation rest □ Education on avoiding back pain □ Education □ Education: The patient demonstrates an unders well as appropriate follow-up. □ YES □ NO □ Other:	trictions x 72 hours about stretching and ba standing of the nature of	their medical condition and	instructions regarding w	worsens. hat they should do a
(Describe) Cold Compress (Acute injury) Warm Co OTC Medications given (Motrin 400 or Tylenol	•	TNO LIYES (If Yes Lis	t):(e	129106
Referral: D NO 22YES (If Yes, Whom/Where)): Dr parbo	44	Date for referral	D. S. I Ole
Referral Type: TRoutine Urgent DEmerg				MM DD YYYY Time
6 . 4. 4			***	≖سهپهسوسسببندنینیه ۲۳۳۳ ۵۰
Nurses Signature	Name	Wambles Pax	<u> </u>	· · · · · · · · · · · · · · · · · · ·
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Nursing Evaluation Tool:

Dermatitis (Rashes)

Ī	Facility: Alabama Department of Corrections
	Patient Name: Boyd, Courtney First Patient Name: Boyd, Courtney First Pate of Pidh:
1	O C C C C > Date of Diff.
į.	Inmate Number: 208931 Time Seen: 20 AM / PM Circle One
	Date of Report: 1 251 Uc Time Seen: 20 ANT Time Seen:
	Diretors DiretScabjes/Nits
Cubio	tive: Chief Complaint: 12-Hiching Burning Redness Swelling Weeping Blisters Lice/Scabies/Nits
Subje	□ Other:
	Onset: X3-4day
	Onset: A D Total Color
Lo	cation: Bilateral groin story: Inmate States & Sometimes the skin comes off. &: (Confirme on back if necessary)
н	story: Inmak States Sometimes The
	(Continue on back if necessary)
	ssociated Symptoms: Thone Tever Tupper Respiratory Symptoms Tongue Swelling/Throat Closing Tracial/Neck Swelling
A	ssociated Symptoms: a None a reverse a opposition of the contraction o
	☐ Difficulty breathing ☐ Other:
F	tecent environmental contacts (allergens/Irritants): <u>ALNUS</u>
	listory of new medication: devices
•	ective: Vital Signs: (If Indicated) T: 988 P: 73 RR: 18 BIP: 20 176 Exam: Lesion(s): 210 DYES Description: Red varsed bumps bilaterally to groin Exam: Lesion(s): 210 DYES (If Yes, Describe): red ness only
Obj	ective: Vital Signs: (If Indicated) 1: 10 Red raised bumps bilaterally to groin
•	Exam: Lesion(s): 10 1 YES Description. 100 1 YES Description: That he could be compared to the country of the c
	Exam: Lesion(s): 100 UYES Description:
······································	Diffhing Dev inmose Joseph
	Additional Examination: HO 101010 Continue on back if necessary)
As	Chamber of Market and
	Referral NOT Required
	Referral NOT Required Referral Required referral due to the following: (Check all that apply) Referral Required referral due to the following: (Check all that apply) Referral Required referral due to the following: (Check all that apply) Referral Required referral due to the following: (Check all that apply) Referral Required referral due to the following: (Check all that apply) Referral Required referral due to the following: (Check all that apply)
	Respiratory distress
	Other
	(Describe)
<u>P</u> :	an: Check All That Apply: ☐ Meds given per approved OTC med list: ☐
	Meds given per approved UTC fried list. Description D
	The patient demonstrates an understanding of the nature of their medical conduitor and income the patient demonstrates an understanding of the nature of their medical conduitor and income the patient for appropriate follow-up visits)
•	Well as appropriate follow-up. BYES INO (If NO then schedule patient for appropriate follow-up visits) well as appropriate follow-up. BYES INO (If NO then schedule patient for appropriate follow-up visits) Production signs and symptoms of severe altergic reaction: (Difficulty breathing, throat or facial swelling). Pt instructed to seek immediate Dreducation signs and symptoms of severe altergic reaction: (Difficulty breathing, throat or facial swelling).
	DEducation signs and symptoms of severe alleryto reaction (chindren) immediate medical attention if these should occur. The profits (If Yes List): AFC apply BID X 2 WEEKS emor
	Other OTC Medications given UNO
	Date for relevant. Do my
	Referral: UTNO LITES (IF res, Mineral fif emergent who was contacted?):
	Referral Type: A Routine Urgent D Emergent (if emergent who was contacted?):
	Name: WWWY OIES Printed
· /	Nurses Signature



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

lature of problem or request:	I need too	ee me Decler es	see it	be will
a le me my back bras	ce and botton	, bec prouse Da	chant to	Se Can
Wolong standing polite to good I also	believe my	the alportal adu	1 my lutters	Care
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•			Signature	
De	O NOT WRITE B	ELOW THIS LINE		
Date:/	_	PECE	EIVED	
Time: AM_PN	M	Date: (a. 12		
Allergies:		Time:		
		Receiving Nur	se Intials	
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	Waiver le	-1200 WB		
		Cala		
(O)bjective (V/S): T:	P:	R:	——ВР:	
(O)bjective (V/S): T:				
(A)ssessment:	· · · · · · · · · · · · · · · · · · ·			
(A)ssessment:				
(A)ssessment: (P)lan:	al Haalsh Dones	Daily Treatment	Return to Cl	inic PR
(A)ssessment: (P)lan:	al Health Dental	Daily Treatment	Return to Cl	inic PR
(A)ssessment: (P)lan: Refer to: MD/PA Menta Check One: ROUTINE (CIRC) EMERGEN	LE ONE CY ()		inic PRI
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(A)ssessment: (P)lan: Refer to: MD/PA Menta Check One: ROUTINE (If Emergency was P	CIRC) EMERGENO HS supervisor not	LE ONE CY () ified: Yes () N	o() o()	inic PRI



Nursing Evaluation Tool:

Back Pain

Facility: Alabama Department of Corrections
Patient Name: Boyd, Courtrey
Inmate Number: 20892 Last Date of Birth:
Date of Report: OG 102 1200 Time Secn: O'S AM/PM Circle One
Subjective: Chief Complaint(s): "I Was Walking and I had Sharp pains to my Loversham Onset: I my back Went out X Sminules 990"
□ New opset □ Chronic condition exacerbation
Pain Scale: (1-10) S Type: Sharp Dult Intermittent Constant Numbress: UNO 1 Yes Location of Pain: 100 bcc Nect / mid-back / low back Radiation of pain: UNO 1 Yes to:
History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back in necessary) History: Stp Back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on back Injury 2003 Blm to have via stratcler per 2 (Continue on bac
Associated symptoms: Pain on urination?
Objective: Vital Signs: (If Indicated) T: 90 P: 14 RR: 18 B/P: 10 180 Back Exam: ☐ Tender to touch ☐ Contusion ☐ Muscle spasms ☐ Impaired range of motion Additional Findings: ☐ Numbness ☐ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other:
Elaborate positive findings: OSdom, Engthern Ur do-trait mited
laverbych
Lower extremities: Display Abnormal (Describe):
Pedal pulses: Let Present Li Auserit
12/ Additional Examination: Pt. Was seen by mo, Earlier this A. ~ ** 5
Continue on death in necessary)
Assessment: (Referral Status) Preliminary Determination(s):
Assessment: (Referral Status) Preliminary Determination(s): Referral NOT Required
Referral Required due to the following: (Check all that apply) Loss of sensation Presence of RBCs from dipstick Prior malignancy Presence of WBCs from dipstick Other. H. Seur Pr. M. Jewy Check all that apply) Recurrent Complaint (More than 2 visits for the same complaint) Description of the same complaint of the same complaint of the same complaint) Referral Required due to the following: (Check all that apply)
<u>Pl</u> an:
Check All That Apply: ☐ Work and recreation restrictions x 72 hours ☐ Education on avoiding back pain ☐ Education about stretching and back exercises. ☐ Instructions to return if condition worsens. ☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should demonstrate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits) ☐ Other: ☐ COLORS
(Describe) Cold Compress (Acute injury) Warm Compress
OTC Medications given (Motrin 400 or Tylenol 650 Bid pm x 2 days) OTC Medications given (Motrin 400 or Tylenol 650 Bid pm x 2 days) OTC Medications given (Motrin 400 or Tylenol 650 Bid pm x 2 days)
Referral: NO YES (If Yes, Whom/Where): Date for referral: / /
Referral Type: Routine Urgent Emergent (if emergent who was contacted?): Time
x McKinnonu Name: S. mcKinnon Cr



图 展 图 8	Nursing Evaluation Tool:	General Sick Call
	Facility: Alabama Department of Corrections	
	Patient Name: DOYO COUT-NEY	
	Inmate Number: 00892 Last Date of Birth:	MI
	Date of Report: 5 1 28 1 500 Time Seen: 130 MM	AM PM Grele One
<u>S</u> ubjed	ctive: Chief Complaint(s): Unlid to get my Onset: Unlid!	profile
	distory: Ho lower back pain	
-11 TO WEST AND		
Objecti Examir (Continue	ive: Vital Signs: (As Indicated) T: 99.1 P: 68 RR: 16 B/P: 18 nation Findings: 61 Auto 40 HCU C 5to on back if necessary) A+0x3 Respectively	Check Here if edditional notes on back 10 / 70 wh. 17 adu Aust
K	equest to see unto for or	chile
de	stress Noted.	Visible
	SSMENT: (Referral Status) Preliminary Determination(s):	☐ Check Here if additional notes on back
ļ	Referral REQUIRED due to the following: (Check all that apply)	
•	Recurrent Complaint (More than 2 visits for the same complaint) Other:	1 /0/20
_	10 tec	() m () 1 m
., -		//
t	Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status he appropriate care to be given.	of the patient or are unsure of
Plan: C	heck All That Apply: Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the nature of their medical condition and instruction as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up.	
ر	J Other	m-up visits)
	edications given NO YES (If Yes List):	
	Date for r	eferral: 5 1281 5Cp
x Se lenal	Type: Routine Urgent Emergent (if emergent who was contacted?): Name: SBUSH UPU	Time
	Nurses Signature Printed	



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

ID # 20892() Nature of problem or req Long Standing Prof	Date of I uest: Tered to S Clerent below	Rirth	Location: 67 Location: 67 Completed of 1997, Seed	12 70
	DO NOT WRITE B	Cocure ELOW THIS LIN	Signature NE	
Date: / / Time: AM Allergies:	PM	RE Date: Time: Receiving N	CEIVED urse Intials	
(S)ubjective:				_
(O)bjective (V/S): <u>T:</u>	P:	<u>R:</u>	BP:	<u>WT:</u>
(A)ssessment:		copy,2	SIN D	al Ro
(P)lan:			206/9	130
	tal Health Dental I	Daily Treatment	Return to Cli	nic PRN
Check One: ROUTINE (If Emergency was F	CIRCLE	d: Yes() N	o() o()	



Follow up

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

ivalure of pro	oblem or request:	Date of B	ection to cap to	Location: 6-1	2 44
ZIO /0/25	SERAMOR PICKLY	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	- CALLO MY	12/20/1/24	09-
21.7 2.0017	CD PIUE, JE, D	ECAUSE MY DO	NU MARCAGO	G 11 caraca +	1112
I will	like to be se	at to a free c	vorly Doctor	atout My pe	y€./(,
			Clerche	Become and the second	·
	D.C	NOT WDITE DA		Signature	
	DC	NOT WRITE BI	ELOW THIS LIN	E	
Date: <u>5</u> /1	16106				
Time: 4	OS AM RM	C	REC	EIVED	
Allergies:			Date:		
			Time: 5	relo6	
			Receiving Nu	rse Intials MA	_
			<u> </u>		
(S)ubjective:	<i>C</i> .	<i>r</i> . <i>i</i>			
	See 1	ult ton	dated	5-110-00	0
			- Cara		
				Clip	<u>ん</u>
(O)bjective	(V/S): <u>T:</u>	P:	Ř:	BP:	WT
		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
(4)		V / New repr			
(A)ssessment	t:	X Surpe			
(A)ssessment	t:	V Courte			
(A)ssessment	i:	X Suche			
	t:	X Buch			
	t:	X Such			
	t:	X Buch			
(P)lan:		X Such			
(P)lan:		Health Dental D		Return to Clin	ic PRN
(P)lan: Refer to: M	ИD/PA Mental H	CIRCLE	ONE	Return to Clin	ic PRN
(P)lan: Refer to: M Check One:	MD/PA Mental H ROUTINE ()	CIRCLE EMERGENCY	ONE ()	Return to Clin	ic PRN
(P)lan: Refer to: M Check One:	MD/PA Mental H ROUTINE () ergency was PHS	CIRCLE EMERGENCY supervisor notified	ONE () : Yes () No	()	ic PRN
Check One:	MD/PA Mental H ROUTINE () ergency was PHS	CIRCLE EMERGENCY	ONE () : Yes () No	()	ic PRN
(P)lan: Refer to: M Check One:	MD/PA Mental H ROUTINE () ergency was PHS	CIRCLE EMERGENCY supervisor notified	ONE () : Yes () No	()	ic PRN
(P)lan: Refer to: M Check One:	MD/PA Mental H ROUTINE () ergency was PHS	CIRCLE EMERGENCY supervisor notified	ONE () : Yes () No	()	ic PRN

WHITE: INMATES MEDICAL FILE



	Nursing Evaluation Tool:	General Sick Call
	Facility: Alabama Department of Corrections	
	Patient Name: Boyd, Courtney	
	Inmate Number: 208921 Last Date of Birth:	MI
	Date of Report: 515100 5160 Time Seen: 410	AM / PM Circle One
<u>S</u> ubjec	ctive: Chief Complaint(s): 1 I need to get see the datur	to get
	my prohles.	
(Continue	tistory: Regrest No prolonged Standing, blanket nathers profile.	and double
(h)	H 1751+ Spoz 9990 normair	Check Here if additional notes on back
	ive: Vital Signs: (As Indicated) T: 980 P: 10 RR: 18 B/P: 1	
Examir (Continue	nation Findings: Blm ambulaks c even, Steady gait Back br	ace intact.
Ken	or ease. Skin warm + dry to touch. do "my hade	als numb
1 30	mino colo, I red a planter, Also do " mu ma	attess is too
-thu	n, 11 males mybonesaine. "Reguest dauble mattress pro-	file. Also states
The	y legs swell up on my sometimes when I'm walking. I	
Asses	ssment: (Referral Status) Preliminary Determination(s): Pulse present 4	SHONG & SWELLING
	A discolaration of the second	of pylonitia hold
	Referral REQUIRED due to the following: (Check all that apply)	han 3 scoras.
	HY CO LBP SINCE 200	3 Reguest to
	Of a bird.	ze for evaluation
-	o · ce out	
ō	Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the statute appropriate care to be given.	17/
t	the appropriate care to be given.	us of the patient or are tinsure of
. 0	Check All That Apply: Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the nature of their medical condition and instructional do as well as appropriate follow-up. PYES DINO (If NO then school to perfect for each of their medical condition and instructional do as well as appropriate follow-up. PYES DINO (If NO then school to perfect for each of their medical conditions and instructions.)	n M
	The first schedule patient for appropriate to	uctions regarding what they llow-up visits)
	Utner:	•
OICM	edications given PNO PES (If Yes List):	
Referral	I: O NO DYES (If Yes, Whom/Where): DY Day Douze Date for Type: Routine O Urgent O Emergent (if emergent who was contacted?):	referral: 5 /18 / 06
Referral	Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):	MM DD YYYYTime
(CWamblespy Name: CWambles Par	
	Printed	



Follow Les

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Still going out on me. DO NOT WE	Signature RITE BELOW THIS LINE
Date://	
Time: AM PM Allergies:	RECEIVED Date: Time: Receiving Nurse Intials
(S)ubjective:	
(O)bjective (V/S): <u>T:</u> P:	: R: BP:
(A)ssessment:	
(P)lan:	
	ental Daily Treatment Return to Clinic I

WHITE: INMATES MEDICAL FILE



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

ID # 208921	Detroit	Date of Re	quest: 4-23	-06
Nature of problem or request: T	Date of	Birth:	ocation: 6-7	3-1
Standing profile, and bel	aule my	army bearly	Jegs Seels	CAN.
is all going out on me.				
		Clear	(m) 134	
DO NO	T WRITE P	ELOW THIS LI	Signature	\
Date: 4 / 33 06				7
Time: AM PM Allergies:		· · · · · · · · · · · · · · · · · · ·	ECEIVED	
Anergies,		Date: Time:		
		47	Nurse Intials	
(S)ubjective:				
See Net	troil	clated 4-	7764	
		Crufter 4-	23-06 	
(O)1:				
(O)bjective (V/S): T:	<u>P:</u>	<u>R:</u>	BP:	
(A)ssessment:				
(P)lan:				
			-	
Refer to: MD/PA Mental Healt			Return to Clin	nic P
Check One: ROUTINE() El	CIRCLE			
If Emergency was PHS supe	MERGENCY	() vd: Ves() N	No ()	
Was MD/PA	on call notifie		No ()	
1,		~ ~ ~	_ \	
	VITAL)	5	
<u>C</u>	TOP	SIGNATURE AN		

WHITE: INMATES MEDICAL FILE

Patient Name:



Nursing Evaluation Tool:

Facility: Alabama Department of Corrections

General Sick Call

Inmate Number: 0000	Date of Birth:	
Date of Report: 4 123 1 CCO	Time Seen: 120	AM / PM Circle One
Subjective: Chief Complaint(s): "I need to get my onset:" months." need to see the doctor brief History:	no piclonged Stai about my arms.	nding profile. Ials legs, and penis going
(Confinue on back if necessary)		
•		
11		
<u>Objective:</u> Vital Signs: (As Indicated) T: 98° P: 72	RR: 16 B/P:_	118 1 Check Here if additional notes on back
Examination Findings: B/M A+0 X3. R lSp & lase. (Continue on back if necessary) EXAMPLE A LOS CONTINUES OF THE PROPERTY OF T	Skin warm + dn	y to touch. Itx
lower balk pain STP ph Since SID phi	isical assault i	n 2003. Does
not radiate per inmate. Clo numbress of bil	ateral arms/1495, a	nd Denis intermittentle
X several months. I swelling or discolomiti	on of extremities	noted Equal Strength
bilateral extremities noted Pedal putse present definite abnormality noted. Repeat L. Spine Y. Ray orde Assessment: (Referral Status) Preliminary Determinate Referral NOT REQUIRED	tumbar Spine Xt red per Dr Darbouze tion(s):	Ray from 4-2105 C. O., on 4-21-06. Progress note
		Darbouze states no stand
Referral REQUIRED due to the following: (Check all the Property of the Same Complaint) Other:	to see ind for	lated. Inmate reguest r cutside referral.
Comment: You should contact a physician and/or a nursing supervisor if the appropriate care to be given.	you have any concerns about the	status of the patient or are unsure of
Plan: Check All That Apply: Instructions to return if condition worsens. Check All That Apply: Check All That Apply: Check All That Apply: Check All That Apply: No (If No the should do as well as appropriate follow-up.————————————————————————————————————	re of their medical condition and en schedule patient for appropria	instructions regarding what they
☐ Other:		*
OTC Medications given PNO PYES (If Yes List):		
Referral: NO PYES (If Yes, Whom/Where): Dr Dav Referral Type: Routine Urgent Emergent (if emergent who was o	DOUCE Da	te for referral: 4 126106
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Time
X Nurses Signature Name: P	Wambles, 12N	



Follow yo

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

		Court	Buil	
	DO NOT WRITE B	ELOW THIS LIN	Signature E)
Date: 4/16/0 Time: 145 Allergies:	AM PM	Date: U	CEIVED OG urse Intials OML	
(S)ubjective:	e het profile	dated 4-1	6-06 wa	
(O)bjective (V/S):	<u>T:</u> <u>P:</u>	R:	BP:	
(A)ssessment:				
	,	Coul B		
(P)lan:	\searrow			

WHITE: INMATES MEDICAL FILE



ij.		g Evaluation Tool:	General Sick Ca
D-4	ility: Alabama Department of Corrections		20
. II Pau	ent Name: Boud, Courtney		
Inm	ate Number: 208921 Last	First Date of Birth:	MI
Date	e of Report: 1 1 1 0 0 YYYY	Time Seen:	
<u>S</u> ubjective: 0	Chief Complaint(s): "I need to a conset: X 2 weeks.	get my profiles u	odata."
Brief History: (Continue on back if n	HX lower back	pain since 2003	
- version consistence en			
			☐ Check Here if additional notes
Objective: \	/ital Signs: (As Indicated) T: $\frac{999}{100}$	P: <u>80</u> RR: 20 B/P:	10 162
Examination Fir	ndings: Blm A+0 X3 Re	op Iven d unla	
(Continue on book if a	+ dry to truch. Reguer	t somewas at Brass	of Chica
Botton		nding profile	MU Spine
	MATTER THE PRINCE STILL	process	
	t: (Potograf Status) - Dealining - F		C) Check Here if additional notes o
Assessment	. (Nelendi Status) - Preliminary i	letermination/e)·	
<u>A</u> ssessment □ Re	ferral NOT REQUIRED	etermination(s):	
□ Re	ferral <u>NOT REQUIRED</u> ferral <u>REQUIRED</u> due to the following: (Check all that apply)	
□ Re	ferral <u>NOT REQUIRED</u> ferral <u>REQUIRED</u> due to the following: (Recurrent Complaint (More than 2 visits for the sa	Check all that apply) ame complaint)	
□ Re	ferral <u>NOT REQUIRED</u> ferral <u>REQUIRED</u> due to the following: (Check all that apply) ame complaint)	
□ Re	ferral <u>NOT REQUIRED</u> ferral <u>REQUIRED</u> due to the following: (Recurrent Complaint (More than 2 visits for the sa	Check all that apply) ame complaint)	
□ Re	ferral <u>NOT REQUIRED</u> ferral <u>REQUIRED</u> due to the following: (Recurrent Complaint (More than 2 visits for the second of the	Check all that apply) ame complaint) HOBY MD	·
□ Re	ferral NOT REQUIRED ferral REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the sa Other: 10 Se LValua t You should contact a physician and/or a nursing	Check all that apply) ame complaint) HOBY MD	he status of the patient or are unsure
Commen the appro	ferral NOT REQUIRED ferral REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the sa Other: 10 Se LValua t You should contact a physician and/or a nursing priate care to be given.	Check all that apply) ame complaint) HOBY MD	he status of the patient or are unsure
Commen the appro	ferral NOT REQUIRED ferral REQUIRED due to the following: Recurrent Complaint (More than 2 visits for the sa Other: 10 be LValua t You should contact a physician and/or a nursing priate care to be given. That Apply:	Check all that apply) ame complaint) HOBY MD	he status of the patient or are unsure
Commen the appro	ferral NOT REQUIRED due to the following: (Precurrent Complaint (More than 2 visits for the sa The triangle of the same of t	Check all that apply) ame complaint) Haby IVD supervisor if you have any concerns about the pature of their realization.	
Commen the appro	ferral NOT REQUIRED due to the following: (Precurrent Complaint (More than 2 visits for the second of the second	Check all that apply) ame complaint) Haby IVD supervisor if you have any concerns about to go of the nature of their medical condition ar IO (If NO then schedule patient for appropriate the sche	
Commen the appro	ferral NOT REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the se Character of the Living and the second of the	Check all that apply) ame complaint) Haby IVD supervisor if you have any concerns about the pature of their realization.	
Commen the appro	ferral NOT REQUIRED ferral REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the sa	Check all that apply) ame complaint) Haby IVD supervisor if you have any concerns about to go of the nature of their medical condition ar IO (If NO then schedule patient for appropriate the sche	d instructions regarding what they iate follow-up visits)
Commenthe appropriate All Dinstruction Should do Other: OTC Medication Referral: D N	ferral NOT REQUIRED ferral REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the se D-Other: 10 You Should contact a physician and/or a nursing priate care to be given. That Apply: Ctions to return if condition worsens. It as well as appropriate follow-up. 12 YES 1 N (Describe) In Sigiven 12 NO 12 YES (If Yes List): 15 O 12 YES (If Yes, Whom/Where): 15 O 12 YES (If Yes, Whom/Where): 15 O 12 YES (If Yes, Whom/Where): 15 O 15 YES (If Yes, Whom/W	Check all that apply) ame complaint) Haby MD supervisor if you have any concerns about to g of the nature of their medical condition ar lo (If No then schedule patient for appropriate to the condition are considered to the condition are condition are conditionally con	d instructions regarding what they iate follow-up visits)
Commenthe appropriate All Dinstruction Should do Other: OTC Medication Referral: Din Referral: Din Reference All Dinstruction All Dinstruction All Dinstruction Referral: Dinstruction Referral: Dinstruction Reference All Dinstruction Ref	ferral NOT REQUIRED due to the following: (Recurrent Complaint (More than 2 visits for the se Character of the Living and the second of the	Check all that apply) ame complaint) Haby MD supervisor if you have any concerns about to g of the nature of their medical condition ar lo (If No then schedule patient for appropriate to the condition are considered to the condition are condition are conditionally con	d instructions regarding what they iate follow-up visits)



Follow left PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Pr	rint Name: Courtney Boyd Date of Request: 4-1-06 Date of Birth: Location: 54-10
N	ature of problem or request: I had Sisped in for dental but I land not
_4	make it because I'm in Segregation. I need to have my thethe
	Colly Mars
	DO NOT WRITE BELOW THIS LINE
	ate: 4/4/00
Ti	me: T35 AM RM RECEIVED Date: Time: Receiving Nurse Intials
(S)	See Net tool dated that
(0	See Waiver atready on dental 11st augnosphietive (V/S): T: P: R: BP: WT:
(A)ssessment:
(P))lan:
Re	fer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN CIRCLE ONE
Ch	eck One: ROUTINE () EMERGENCY () If Emergency was PHS supervisor notified: Yes () No () Was MD/PA on call notified: Yes () No ()
	SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE





PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

	Print Name: Lowerney Boyd	Date of Request: 3-23-86
	ID # 20892/ Date of Bir	th: Location: S-A-10
	Nature of problem or request: Tan in Socre	mark land and the stand and a second
	profile Also T need to see the Dental	and we back brace and bottom bed
	MICA THE Thees to see the Dantal	prochat have my tacks filled
	Also I meet my Double tray profit	E repeule
		Signature
	DO NOT WRITE BEI	
	Date: 3 /25/ 64	
	Time: 7'. 4 AM RM Allergies: NUM	RECEIVED Date: Time: Receiving Nurse Intials
	(S)ubjective: See	
	(O)bjective (V/S): T: P:	R: BP://8/ WT:
	(A)ssessment:	
	(P)lan:	
	Refer to: MD/PA Mental Health Dental Dai	
	CIRCLE Of Check One: ROUTINE () EMERGENCY (If Emergency was PHS supervisor notified: Was MD/PA on call notified:	Yes() No()
v	_ Ovar	
	SIG	NATURE AND TITLE
	WHITE: INMATES MEDICAL FILE	

WHITE: INMATES MEDICAL FILE



B 888	Mursing Evaluation Tool: General Sick Call
.	Facility: Alabama Department of Corrections
(Patient Name: Boyd Courtney
	Inmate Number: 20894 Date of Birth:
	Date of Report: 3 26 000 Time Seen: 7, 10 AM APM Circle One
Brief His	ive: Chief Complaint(s): Need Wack Unus and bottom bed proposetions: 3-25-04 story: ") need to get a reach show and a bottom bed propose
Examinal	C) Check Here I additional notes on back D) Wital Signs: (As Indicated) T: 98 P: 67 RR: N B/P: 1/2 1 64. Sign Findings: 40 V UTULE pour from j umpin on t 97 + 40 Downki
	ment: (Referral Status) Preliminary Determination(s):
	Referral NOT REQUIRED Referral REQUIRED due to the following: (Check all that apply) I Recurrent Complaint (More than 2 visits for the same complaint) I Other:
Con	ument: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of
Plan: Chec □ li □ E shou	k All That Apply: instructions to return if condition worsens. ducation: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they lid do as well as appropriate follow-up. CI YES CI NO (If NO then schedule patient for appropriate follow-up visits) Ther: Described
	ations given O NO O YES (If Yes List):
Referral Tvr	2 NO DYES (If Yes, Whom/Where): Dr Dash Dr. Date for referral: 4 13 150
	De: D-Röutine D Urgent D Emergent (if emergent who was contacted?): Time
	Name:



Nursing Evaluation Tool:

Dental Complaint

II Facility: Alahama Dehartment of Cottections	7
Facility: Alabama Department of Corrections	
Patient Name: Boyd Courtney Last First MI	
Inmate Number: 20 8021 Date of Birth:	
Date of Report: 3 125 1 Circle One Time Seen: 7' C AM PM Circle One	
Subjective: Chief Complaint(s): Request tooth & Olon	
Onset: 3-25-07	
History: ") need to see the dentist" (Continue on back if necessary)	
O Check Here if additional no	otes on back
Is the problem: Description of Chronic Problem related to: Recent trauma Recent dental work Other: Injury sustained in altercation with custody staff, or other inmate: Description of Correctional Staff) Dental Pain: Right: Upper Back Upper Front Lower Back Left: Description Upper Fr	
Objective: Vital Signs: (If Indicated) T: 98 P: 64 RR: 18 B/P: 1/2 1 64	
Visual evidence of tooth decay/fracture	⊒Yes ⊒Yes
C) Additional Examination:	1100
Continue on back if necessary)	
Cleck Here if continued on	rback .
Assessment: (Referral Status) Preliminary Determination(s): Referral Not Required	rback .
Assessment: (Referral Status) Preliminary Determination(s): Referral Not Required Referral Required due to the following: (Check all that apply) Fever Solution or swelling	rback .
Assessment: (Referral Status) Preliminary Determination(s): Referral Not Required Referral Required due to the following: (Check all that apply)	•
Assessment: (Referral Status) Preliminary Determination(s): Referral Not Required Referral Required due to the following: (Check all that apply) Fever	•
Assessment: (Referral Status) Referral Not Required Referral Required due to the following: (Check all that apply) Preliminary Determination(s): Referral Required due to the following: (Check all that apply) Preliminary Determination(s): Referral Required due to the following: (Check all that apply) Preliminary Determination(s): Referral Required due to the following: (Check all that apply) Preliminary Determination(s): Referral Required due to the following: (Check all that apply) Recent dental surgery/procedure Preliminary Determination(s): Referral Required due to the following: (Check all that apply) Recent dental surgery/procedure Preliminary Determination(s):	an 2 visits)
Assessment: (Referral Status) Referral Not Required Referral Required due to the following: (Check all that apply) Fever	an 2 visits) are unsun
Assessment: (Referral Status)	an 2 visits) are unsun
Assessment: (Referral Status) Referral Not Required Referral Not Required	an 2 visits) are unsun
Assessment: (Referral Status) Referral Not Required Referral Not Required	an 2 visits) are unsun
Assessment: (Referral Status) Referral Not Required Referral Not Required	an 2 visits) are unsun

DEPARTMENT OF CORRECTIONS TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record	RELEASED: /mm/ate/Hea	Ith Record	ALLERGIES:	
Institution: Easterly	Institution:	ore	1 4 ~6	~ / _
Cizno and	@ 1015	1200		7 VI
Date Time: AID AMPM RECEIVED FROM:	Date: U (NO) Time	e: AM/PM	PHYSICAL EXAM	MINATION
Institution/Work Release Center/Free-World Hospital	Infirmary	Segregation	Date of last exam	: 12/17/08
	Population	Mental Health	Chest X-Ray Date	e: Result:
RECEIVING MEDICAL STATUS	Other		PPD Reading	12/19/NIEM
Population	RELEASE TO			Who to have
Infirmary	DOC Infirm	nary Mental Health	Classification:	
C testados			Limitations:	
Isolation	Institution/Work Release (Center/Free-World Hospital		
LAB RESULTS LAST REPORT		1	YES NO	
Date Norma	Abnormal	Wears Glasses/Contac	ts 🔲 🔀	
Urinalysis 2378		Dental Prosthesis		17
		Hearing Aide Other Prosthesis	그렇다	Suriun
CURRENT OR CHRONIC-MEDICAL/DENTAL/MENTAL	L HEALTH PROBLEMS O		Recie	eving Nurse
the state of the s	- TIESTE THE THOOLEMS O	TOOMITE AND TO THE STATE OF THE	*	Control of the second state of the second stat
coroin hash				
CURRENT MEDICATION DOSAGE AND FREQUEN	ICY	MEDICATIONS	70	
		MEDICATIONS L X-RAY FILM	Sent w / inmate Sent w / inmate	Not sent w / inmate Not sent w / inmate
Wether Food brotig	X 60 dass	1	Sent w/inmate	Not sent w / inmate Not sent w / inmate
(110)	7	Released to:	ociii iyi iiiilale	140t Selik M / Hittligfe
470 <u>0</u>				
A		Date:	Time: _	AM/PM
TLO		MEDICATIONS	Received	Not Received
(b) C		X-RAY FILM	Received	Not Received
			Received	Not Received
SCHEDULE FOR CHRONIC CARE CLINIC	ļ	/ \ \ \ \ \	YES	² □ NO
DATE: LAST QUINT:			f Receiving Nurse	<u> </u>
- Locky		Date: 8-1		2125
FOLLOW-UP CARE NEEDED Date	Time With Who	om Location (Sending Nu		AM/PM Appt. Made w/Whom (Rec. Nurse)
Medical Denta N M		coodion (ochaing radi	Date/F	ppt. Made w/whom (Hec. Nurse)
Mental Health				
- Montal / Todali				
Ves No Drug Use	Open Sores	Yes No	INTAKE	
Mental Illness	Lice		Sick Call Proc	edures Explained
Mental Illness Suicide Attempt	Lice Edema Warm & Dr. Cool & Mois NO. Alert Oriented Uncooperate Uncooperate		Height	59"
Chronic Care	Warm & Dr	·	Weight	176
the Coord Diet	a mulium and a mul		Blood Pressur	e 110,70
Special Diet Appearance	Alert Oriented	V	Temperature	984
OTHER PERTINENT NURSING ASSESSMENT	Alert Oriented Uncooperat One Depressed	tive	Pulse Resp.	
(Noted from health	Depressed		Other	
	Elido	(N) = == :	D	2 17 ~
Signature of Nurse Consolering Asses ment (Sending Nurse)	(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 1-1. X 1/V a. (1 U \ V	X-1/4/
s (table)	Dale	Signature of Intake Screening North	rse (Receiving Nurse)	Date
INMATE NAME (LAST, FIRST, MIDDLE)	Date	Signature of Intake Screening Null	rse (Receiving Nurse)	Dale Race/Sex FAC.

٠.	Π,

	Nursing Evaluation Tool:	Chest Pain
	Facility: LASTY 97	
	Patient Name: Doyd CoulTway	
	Inmate Number: 2089 2/ Date of Birth:	
	Date of Report: 17 1 2005 Time Seen: 815 Al	M (PM) Circle One
Subjectiv History: (Continue on b	Onset: About 15 min An Activity prior to onset: STAND. STATU IN Fort LTISING ALL WAY TO CLOSS back if necessary)	S 4p M/King
Descript	tion of Pain: Burning Stabbing Dull/Achy Pressure-like Crushing Other:	☐ Check Here if additional notes on back
Duration Onset of Radiatio Aggrava	Does anything relieve the pain? No radiation	y of injury? □ YES □ N O
ASSULIAI	Risk Factors: Nausea/Vomiting Diaphoresis Dyspnea Syncope Cough Sputum	
	: Vital Signs: (As Indicated) T: 96 P: 61 RR: // B/P: 104 Pulse Ox %: 97 % Room Air 0 02 LPM: 97 %	160
COIOI.	Appearance: ☐ No acute distress	Lung sounds: Clear Left Clear
EKG ord	dered? AYES INO	Diminished
	erpretation / computer read or available for physician 22 YES NO	Rhonchi
Additio Conti	onal Examination: Alox3 able to Carry on Canceration	Wheezing D
et	has sensotion line all extremetics	3
<u>A</u> ssessme □ Refer	ent: (Referral Status) Preliminary Determination(s):	Check Here if continued on back
Comm	ral Required due to the following: (Check all that apply) Acute distress	
	ck All That Apply: Acute distress – arrange for immediate emergency transport administer oxygen if in acute distress	ts)
OTC Medic	cations given I NO PYES (If Yes List): Mylanta take Tu	lienal lim
Releifal.	A NO CITYES (II Yes, Whom/Where): Date for refe	
Referral Ty	pe: Routine Urgent Demergent (if emergent who was contacted?):	WW DO YYYY
× CAC	Name: Carcia Um Norses Signature Name: Printed	



ADMISSION DATE JUNE JORIGINATING FACILIT	N SIMMO
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NURSE'S SIGNATURE DATE HYSICIAN'S SIGNATURE DATE HYSICIAN'S SIGNATURE	DATE CONSULTATION
INMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB R/S FAC.
177- 4 Courtnois	D.021 89 1000



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Date/Time	Inmate's Name: Boyd Coultury	D.O.B.: / /
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50111 (5/85)	Complete Both Sides Before Using Another Sheet	1/1/



Date/Time	Inmate's Name: Boy Courtney D.O.B.:
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04/08/0	5 to per Nep re: 9/4 eye
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i0111 (5/85)	(No Per cogesic) Grander Sheet Complete Both Sides Before Using Another Sheet
	Complete Both Sides before Using Another Sheet



Date/Time	Inmate's Name:	D.O.B.:	/ /
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Date/Time	Inmate's Name: Boyd, Courtney D.O.B.:
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Date/Time	Inmate's Name: D.O.B.:
3/30/04	WH.173 BIP 110/70 P-94 RIG
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Date/Time	Inmate's Name: Boyd, Countries D.O.B.:
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-0111 (5/85)	Complete Both Sides Before Using Another Sheet



Date/Time	Inmate's Name: D.O.B.: /	
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	handy profiles to the Tor. 4	hen
	he allr. Bond) offered his back	
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	to give it the the nirse Mr	Boul
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	got up & walked out laughing	-)
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	Conce Mudu	reta
111 (5/85)	Complete Both Sides Before University of the Complete Both Sides B	

	
Date/Time	Inmate's Name: Boyd, Courtney D.O.B.:
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Date/Time	Inmate's Name:	D.O.B.:
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Date/Time	Inmate's Name: Boyd, Countrey D.O.B.:
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50111 (5/85)	Complete Both Sides Before Using Another Sheet

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	٠			•	Request F	om		
Inmate	Name_	Burker	Bush			Date of Requ	vesi/0-2	5-0
JS No	o. <u>10</u>	89/10/	Date	of Birth		Housing Loc	D-1-91	3
Nature	of probl	em or request	OMu bo	ck hes	bee herting	very bad	48/15	7
					See 1 miles			
Hear	Drok	lans.		No.		3		!
Sign here	forcon	isent to be trea	ated by health	staff for the c	ondition describe	d above. Coris	h Dec	
	:		Place this s	lip in Medic	al Box or desi	gnated area	- 6	James Sand
			DO NO	T WRITE	BELOW THE	CENTER		- 4
4 to at at at 44 to at at 45 to 45 t	; <u> </u>					Belli Da, 13	J 3 8 200	03
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Education:				•		•		
	 		·					-
	 							
ocol used: (specify)							
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Date/Time	Inmate's Name: Boyd, Courtney D.O.B.
08/13/04	To see HCP for Hy back pain
Wg	t. 160, 97.4 18, 98/70, 0297, 64.
	14 has back brace Stoles That his lower back
	continues to hunt & burn, When pt is asked
	to detail the nature of his pour allevioling/aggrowing
	factors & specific regions of leg poin ties he
	is intentionally nonspecific tis a difficult
	Mistorian
	1 AAOX3 Spine whine MTTP
	QSLB. 2+ 1 ext PTR S/5 strongly
	M. 17/1 Back pain
	Suspect molingering
. 1 /	JAN Curl
2/2/69	B098/44 T974 P84 R20
WT 140	0,0801
	5-I come for my weight is.
	8/13-140 10/16/04/62 11/10/- 140 11/164/140
	8/13-160 10/16/04/62 11/10/1-140 11/164/140 6-2-64 168 Loden 140.
1/5/04	20 NCP re: Tu on back
111+141)	983 82 20 979 100/2
	S. I have back dain i mablem & my was i my wit
	0-Multiple 6 3 objective Jala to Support. Stales
	Didnot get personer opth but siened in manda Same
60111 (5/85)	Complete Both Sides Before Using Another Sheet



	# %:
Date/Time	Inmate's Name: Boyal, Country \$9592/ D.O.B.: / /
8/6/04	Inmate's Name: Boyal, Courtney \$9892/ D.O.B.: 1 1 No Show for Sich Call - Spleasard No Show for Sich Call - Lellic Keory
5/27/85	No Slow for Sich Call - alling Kegling
2/0 (0	



		0 0				
Date/Time	Inmate's Name:	Boyd, Cour	trey		D.O.B.:	
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3/5/02 139 6/18/03 131 150 3/11/04



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: [Number Day Date of Request: 3-70-04] ID # 20892 Date of Birth: Location: N-36 Nature of problem or request: T. Need another back brace for my back, because Tim Still having problems with 't. Also need my double portion profile, so that I will obje to get my weight back. Both of these profile and in my weight back. Both of these Signature DO NOT WRITE BELOW THIS LINE
Date: 3 132 10 4 Time: 640 AM PM Allergies: NK4 100/64- 50-20-978 1584/ Receiving Nurse Intials 100 Receiving N
(S)ubjective: I'm having just lose 12 LBS in 15 days. I had a back brace + I need it back. I had a people for double partions I need it back. (O)bjective a + 0 x 3. Pesp reg c ease. V 5 WNL
(A)ssessment: alt. in comfort RfT above statement
(P)lan: See Cur P
Refer to: MD/PA Mental Health Dental Daily Treatment CIRCLE ONE Check One: ROUTINE () EMERGENCY () If Emergency was PHS supervisor notified: Yes () No () Was MD/PA on call notified: Yes () No () The control of the supervisor of the sup

WHITE: INMATES MEDICAL FILE VELLOW INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Date/Time	Inmate's Name: Boyd, Courtney D.O.B.: / /
3/22/04 e	22 ylo BM requests a back brace & double
0935	portions e meals due to ut. loss.
	PMHX - 1) wt. Loss? 3) Fine Acid Reflux
	2) LBP
	VSS:, Alo x3
	Hunt - 5,52 , RRR
	longs - ctrrB
	And Benign
	m.s Full Rom, Ant. = case; neuro (); &
	point TND or sbriens deform.
	wt. loss ? 3/5/62 - 139/6
	4/18/03 - 138 16
	3/11/04 - 150 16
	3/22/04 - 158/16
	- Pt. has gained ~ 20 125 sine 3/5/02
	i) wt. 1055 - Pt. gainel ~ 20 15
	or indication for double partions
	- weigh a month × 6 mos
	2) Low buck pain - b clinical findings
	- Tylerol X 7 d PR
	- moist heat
	3) Arid Reflux
	- Anthrids ii p.o. BID x 30d PR
	RTC in 2 mos.
60111 (5/85)	Complete Both Sides Refore Using Another Sheet



Date/Time	Inmate's Name: Boyd, Courtney	D.O.B.
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PHYSICIÁN PROGRESS NOTES

PHYSICIAN PROGRESSING ES			
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